

A Proposed Approach

Identifying Designated Providers Under Rule Chapter 850 Access Standards

September 19, 2003

Prepared by: Maureen Booth
 Gino Nalli
 Taryn Bowe

 Institute of Health Policy
 Muskie School of Public Service
 University of Southern Maine

Prepared for: Bureau of Insurance
 Maine Department of Professional and Financial Regulation

This report was prepared as part of a Cooperative Agreement between the Maine Department of Professional and Financial Regulation and the Muskie School of Public Service, University of Southern Maine. Views and conclusions are the authors' and do not represent official policy of the Maine Department of Professional and

Financial Regulation or the University of Southern Maine.

Table of Contents

Background.....	1
Context.....	1
Scope and Approach of the Project.....	2
Literature Review	3
Interview Findings	10
Conclusions and Recommendations	13
Appendix A: Key Informants	
Appendix B: Interview Protocol	
Appendix C: Quality Measurement Tools	

Background

In June 2003, the Maine legislature enacted Public Law 2003, Chapter 469 (hereinafter referred to as “Chapter 469”), an extensive law to provide coverage to Maine’s uninsured population as part of an overall reform of the state’s health care delivery system. Chapter 469, also known as *Dirigo Health*, amends the Insurance Code related to minimum requirements for geographic access to providers. Chapter 469 permits a carrier to provide financial incentives encouraging members to use designated providers for a limited set of services insofar as these providers meet specified quality standards. At no time can incentives require travel in excess of 100 miles or 2-hour travel time under normal conditions.

Chapter 469 instructs the Superintendent of the Bureau of Insurance (BOI) to provisionally adopt rules by January 1, 2004 regarding the criteria used to determine whether a carrier’s health plan meets the requisite quality standards. BOI contracted with the Muskie School of Public Service to assist in the formulation of criteria to evaluate compliance with Chapter 469’s quality standards.

Context

Section E-20 of P.L. 2003, Chapter 469 amends the conditions set forth in 24-A MRSA §4303(1) for evaluating the adequacy of a health plan’s access to providers. Chapter 469 provides for financial provisions designed to encourage enrollees to use designated providers in a network, upon approval of the Superintendent, if:

- (1) *The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850.* Current standards require primary care services to be available within 30-minute travel time, and specialty care and hospital services to be available within 60-minute travel time from an enrollee’s residence.¹ The net effect of this provision requires health plans to use qualified providers within the standard travel times. If no participating agreement exists with a qualified provider within the standard travel times, the health plan is still obligated to pay for appropriate services rendered to the enrollee.
- (2) *The health plan is consistent with product design guidelines for Rule Chapter 750,* including covered services and maximum cost sharing arrangements. We have interpreted the intent of this provision to mean that a financial incentive is an additional benefit enjoyed by the enrollee in accessing the designated provider. BOI interprets the law as not permitting a reduction in benefit coverage as an allowable “financial provision” to direct enrollees away from a non-designated provider located within current geographic limits.
- (3) *The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services as defined in Rule Chapter 850.* Generally speaking, this provision limits designation to services provided by hospitals, outpatient surgical centers, and certain

¹ According to Subsection 7C(2) of Rule Chapter 850, 60-minute travel time is equivalent to 40 miles in areas with primary road available; 30 miles in areas with only secondary roads available; and 50 miles in areas connected by interstate highways.

specialists. This provision further protects against use of designated providers for routine follow-up care.

- (4) *The financial provisions may apply to all of the enrollees covered under the carrier's health plan.* This provision clarifies that the approval of financial incentives to use designated providers is product specific. Once approval is obtained for a particular product, the carrier may market that product without obtaining separate approvals for each contract issued, and the financial provisions in the product may apply to all enrollees covered under the product. Conversely, a carrier would have to obtain separate approvals for financial incentive provisions in different products marketed by that carrier.
- (5) *The carrier establishes to the satisfaction of the Superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services.* The burden of proof is on the carrier to demonstrate:
- that the designated provider provides better quality service than service providers within the standard travel time;
 - the nature and extent of any detrimental impact to covered persons; and
 - that service quality of the designated provider outweighs the detrimental impact OR that the carrier has mitigated the detrimental impact.
- (6) *The financial provisions may not permit travel at a distance that exceeds the standards established in Rule Chapter 850 for mileage and travel time by 100 percent (see note 1).* At no time can designated providers be located more than 2 hours (or 100 miles) from an enrollee's home (twice the allowed standard travel time/distance for specialty care).

The following example illustrates the effect of the above provisions. For an allowed service, there is one provider within the 60-minute and 50-mile distance limits of Rule Chapter 850 and a second who is outside these limits BUT within the 2-hour limit (and 100 miles) allowed by Chapter 469. The carrier can financially incent an enrollee to use the second provider, presuming that better quality services are provided by the second provider and all other requirements are satisfied. The carrier must continue to contract with the first provider or, if the first provider refuses participation status, the carrier cannot financially penalize an enrollee who chooses to use the first provider. Essentially, the carrier can establish a designated provider network that is a subset of the health plan's existing participating network.

Scope and Approach of the Project

Under terms of a Cooperative Agreement with BOI, the Muskie School of Public Service was requested to provide technical support in developing criteria for analyzing filings made pursuant to the quality provisions set out in Item #5 above. Three deliverables were specified:

- Criteria for evaluating the quality of services.
- Criteria for evaluating detrimental impact.
- Criteria for assessing methods to mitigate against detrimental impact.

BOI will use project findings to inform the rulemaking process required under Chapter 469.

The project focused on two methods for providing the requested assistance. First, Muskie School staff conducted a review of the literature and state practices to assess existing techniques, criteria and indicators for measuring service quality and detrimental impact. Second, project staff arranged and conducted structured interviews with key informants representing policy, payor, consumer and provider interests. A total of 14 interviews with 29 individuals were conducted; 4 in-person, 9 via telephone, and 1 via video-teleconferencing (see Appendix A for list of key informants). Other stakeholders were invited to participate but were unable to do so during the project period. An interview protocol was shared with informants prior to the interview (see Appendix B). One or more representatives from BOI observed the interviews.

This report documents the findings and conclusions of the literature review and interviews. While every effort has been made to address opinions expressed in the interviews in the development of our recommendations, it was not always possible to find a consensus position that satisfied all perspectives on an issue. The authors, however, have attempted to identify the trade-offs and implications of the proposed actions. Views and conclusions are the authors' and do not represent official policy of the Maine Bureau of Insurance or the University of Southern Maine.

Literature Review

The purpose of the literature review was to consider available techniques and indicators for assessing quality and detrimental impact. The threshold standard for a carrier to designate a provider for a financial incentive program is evidence that service quality of that provider is better than providers located within standard travel limits. Once quality is determined to be better, a carrier must demonstrate that benefits accrued from better quality offset any detrimental impact imposed by longer travel times, or that there is sufficient mitigation by the carrier of detrimental impact to the enrollee.

Literature from the following sources was reviewed to identify approaches for assessing quality and potential detrimental impact:

- National accreditation standards for hospitals and managed care organizations (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], National Committee for Quality Assurance [NCQA])
- National, standardized quality measurement sets (e.g., Leapfrog, Health Plan Employer Data and Information Set [HEDIS], JCAHO's ORYX Initiative, HealthGrades, Agency for Healthcare Research and Quality -- Quality Indicators [AHRQ-QI], National Quality Forum Serious Reportable Events)
- Private and public initiatives for reporting and differentiating quality across providers (National HealthCare Report Quality, federal criteria for designating critical access hospitals, Ford Motor Company Hospital Profiling Project, Maine Health Care Performance Council)
- Large networks of providers and managed care organizations (AETNA, Anthem Blue Cross and Blue Shield, California Health Care Foundation, MediCal)
- Quality improvement organizations (e.g., federally designated Quality Improvement Organizations [QIOs], Vermont Program for Health Care Quality)

- Consumer protections and regulations governing quality of care and access to services (e.g., Maine BOI Rule Chapter 850; Minnesota Rules 620.124 and 4685.1010, Access Guidelines and Geographic Accessibility).

Assessing Quality

The literature addressed quality from four perspectives:

- *The clinical outcome of care.* These included evidence-based standards for evaluating the delivery of services or procedures on an absolute or relative scale.
- *Clinical processes of care* believed to lead to positive quality outcomes.
- *Structural aspects or systems of care* that are associated with improved quality.
- *Consumer experience* with care and ratings of quality.

Each type of measures helps to explain one piece of the quality puzzle. The combination of two or more of these measures yields a more comprehensive view of the quality of care. However, constraints on time and money and the availability of valid and reliable data may limit the feasibility of collecting information on multiple measure types.

An underlying issue to consider when using measurements is the capability to generalize. In most instances, one cannot generalize about the overall quality of a hospital or physician from measures that focus on a specific service or are limited to a narrow range of conditions and procedures.² Where possible, assessments of quality are best done at the service or condition level.

The following sections elaborate on the different methods for assessing quality and provide examples of the different standards and measures used to evaluate quality of care.

² Brook, RH, McGlynn, EA, and Cleary, PD. 1996. Part 2: Measuring Quality of Care. *The New England Journal of Medicine*. 335(13) 966-970.

1. The clinical outcome of care

Quality can be measured by looking at the clinical outcome of care. Mortality and complication rates and the prevalence of adverse events provide information on the levels of health and disability in populations who have recently received health care. When these outcome measures are tied to specific conditions or procedures the link between processes and outcomes can be more clearly established.³ Quality assessment systems that include clinical outcome measures often rely on statistical adjustment models and stratification methods to address population differences and allow for meaningful comparisons across institutions and providers.⁴ HealthGrades Hospital Ratings, Ford Motor Company's Hospital Profiling Project, and California's Coronary Artery Bypass Graft Surgery Mortality Reporting Program are all examples of quality measurement systems that use risk adjustment to account for population variance when comparing clinical outcome measures.

Another clinical outcome of care frequently cited in the literature is the relationship between patient mortality and procedure volume. Higher provider volumes of select high-risk procedures and conditions are linked to lower surgical mortality rates.⁵ Although a relationship between volume and outcomes has long been recognized, large-scale efforts to reduce surgical mortality by concentrating select procedures in high-volume hospitals have only recently begun to catch on. The Leapfrog Group leads the most well known of these efforts. As part of its hospital safety measures, Leapfrog has established minimal volume standards for six high-risk procedures, including coronary-artery bypass surgery, percutaneous coronary intervention, abdominal aortic aneurysm repair, pancreatic resection, esophagectomy for cancer, and high-risk delivery. The exact volume standard for each of these procedures is included in the table on the following page.

³ Institute of Medicine, Committee on the National Quality Report on Health Care Deliver. 2001. Envisioning the National Health Care Quality Report. Washington, DC: National Academy Press.

⁴ Institute of Medicine, Committee on the National Quality Report on Health Care Deliver. 2001. Envisioning the National Health Care Quality Report. Washington, DC: National Academy Press.

⁵ Halm, EA, Lee, C, and Chassin, MR. 2002. Is volume related to outcome in health care? A systematic review and methodologic critique of the literature. *Annals of Internal Medicine*. 137:511-520.

TABLE 1. CLINICAL OUTCOME STANDARDS

<u>Standard</u>	<u>Clinical Outcome Measures</u>	<u>Applications</u>
<p>Agency for Healthcare Research and Quality (AHRQ) Quality Indicators</p> <p>www.qualityindicators.ahrq.gov/data/hcup/qinext.htm</p>	<p>A set of quality indicators organized into 3 modules:</p> <p>(1) Prevention – rates of admissions that could have been prevented through quality outpatient care;</p> <p>(2) Inpatient Quality – inpatient mortality rates for procedures and conditions, utilization rates for procedures where there may be overuse, under use, or misuse, and procedure volumes;</p> <p>(3) Patient Safety – surgical complications and adverse events.</p> <p>*NOTE: Indicators are based on claims data which may not provide the most accurate clinical information since its primary purpose is for payment.</p>	<p>All three modules rely solely on hospital inpatient administrative data and were designed for use by health care decision-makers.</p>
<p>HealthGrades Hospital Ratings</p> <p>www.healthgrades.com</p> <p>*Similar methodologies are used in Ford Motor Company’s Hospital Profiling Project, and California’s Coronary Artery Bypass Graft Surgery Mortality Reporting Program</p>	<p>Hospitals earn 5, 3, or 1 star(s) for performance depending on the difference between actual and predicted mortality/complication rates. Ratings are given for cardiac surgery, cardiology, orthopaedic surgery, neurosciences, pulmonary/respiratory, vascular surgery, and obstetrics.</p> <p>*NOTE: Indicators are based on claims data which may not provide the most accurate clinical information since its primary purpose is for payment. A JAMA study evaluating HealthGrade’s hospital rating system for acute myocardial infarction concluded that while the rating system identified groups of hospitals that, in the aggregate, differed in their quality of care and outcomes, the ratings poorly discriminate between any 2 individual hospitals’ process of care or mortality rates.⁶ Also, ratings are based on a single payer’s information (Medicare).</p>	<p>HealthGrades is a private company that offers online reports on over 5,000 hospitals. The site does not give each hospital an overall rating, but rather provides separate ratings on 25 different procedures.</p>
<p>National Quality Forum’s (NQF) Serious Reportable Events in Healthcare</p> <p>Serious Reportable Events in Healthcare, The National Quality Forum, 2002</p>	<p>List of 27 serious adverse events organized into 6 categories: surgical; product or device; patient protection; care management; environmental; and criminal acts.</p> <p>*NOTE: Serious adverse events may be too rare to allow for differentiation between providers.</p>	<p>Designed as required reporting elements for all licensed healthcare facilities. Additional specifications for data collection and reporting are under development.</p>

⁶ Krumholz, HM, Rathore, SS, Chen, J, Wang, Y, Radford, MJ. 2002. Evaluation of a consumer-oriented internet health care report card: The risk of quality ratings based on mortality data. *JAMA*. 287(1)1277-1287.

TABLE 1. CLINICAL OUTCOME STANDARDS

<u><i>Standard</i></u>	<u><i>Clinical Outcome Measures</i></u>	<u><i>Applications</i></u>
Leapfrog Evidence-Based Hospital Referral www.leapfroggroup.org	Procedural volume thresholds for 6 select surgical procedures: coronary-artery bypass surgery (450/year), percutaneous coronary intervention (400/year), abdominal aortic aneurysm repair (50/year), pancreatic resection (11/year), esophagectomy for cancer (13/year), and high-risk delivery (regional neonatal ICU 15/day). *NOTE: Volume standards generally favor large, secondary and tertiary hospitals over small, primary acute facilities. The measures focus on services and procedures that are predominately located in larger hospitals.	Leapfrog member companies agree to base their purchase of health care on principles encouraging more stringent patient safety measures. The volume thresholds shown here make up 1/3 of health care provider performance comparisons and hospital recognition and reward.

2. Clinical processes of care

Measures of clinical processes focus on the various aspects of health care delivery and reflect what is actually done during the course of treatment. Process measures often assess a provider's compliance with evidence-based practice guidelines and may track activities such as a provider's adherence to appropriate intake and discharge protocols, administration of specific tests and preventive measures, provision of information, and general and procedure-specific prescribing practices.

TABLE 2: CLINICAL PROCESS STANDARDS

<u><i>Standard</i></u>	<u><i>Clinical Process Measures</i></u>	<u><i>Applications</i></u>
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Hospital Core Measures www.jcaho.org/pms/index.htm	4 focus areas: (1) Acute Myocardial Infarction; (2) Heart Failure; (3) Community Acquired Pneumonia; (4) Pregnancy + related conditions. *NOTE: Measures are based on claims data. Claims may not provide the most accurate clinical information since their primary purpose is for payment.	JCAHO is the nation's leading accreditor of hospitals. Compliance with JCAHO standards is required for accreditation. Additionally, JCAHO measures are used as part of CMS's Hospital Quality Information Initiative and the QIO's work with hospitals.
Health Plan Employer Data and Information Set (HEDIS) measures www.hprc.ncqa.org	Standards and performance measures in 5 broad categories: (1) Effectiveness of care; (2) Access/availability of care; (3) Satisfaction in experience with care. *NOTE: Measures focus on primary care and can be based entirely on claims data.	HEDIS measures are used to evaluate managed care and fee-for-service plans and provide information to consumers. The National Committee for Quality Assurance (NCQA) uses HEDIS to accredit health plans.

3. Structural aspects or systems of care

Structural measures reflect the organizational, technological, and human resources infrastructure of the system thought to be necessary for high-quality care.⁷ They gauge the presence of systems (administrative, computer, and/or management) linked to improved provider performance, patient safety, customer service, and clinical outcomes. Computer physician order entry is one structural aspect of care that has been shown to significantly reduce serious prescribing errors in hospitals.⁸ Staffing intensive care units (ICUs) with physicians who have credentials in critical care medicine is another structural innovation shown to improve quality by contributing to lower patient mortality.⁹

TABLE 3: STRUCTURAL STANDARDS

<u><i>Standard</i></u>	<u><i>Structural Measures</i></u>	<u><i>Applications</i></u>
Leapfrog Patient Safety Standards www.leapfroggroup.org	(1) Computer Physician Order Entry; (2) ICU Physician Staffing. *NOTE: Standards are derived from studies conducted in urban hospitals and are not necessarily applicable to small, rural facilities.	Leapfrog member companies agree to base their purchase of health care on principles encouraging more stringent patient safety measures. The structural measures shown here make up 2/3's of health care provider performance comparisons and hospital recognition and reward.
Critical Access Hospital Standards Balanced Budget Act of 1997 (Public Law 105-33)	Includes requirements for: (1) compliance with licensure and certification requirements; (2) participation in a rural health network; (3) formation of credentialing and quality improvement assurances; (4) provision of 24-hour emergency services, (5) provision of 24-hour nursing services; and (6) physician oversight of inpatient services provided by a physician assistant, nurse practitioner, or clinical nurse specialist. *NOTE: Standards are global and not service-specific.	Federal criteria for participation in the Medicare Rural Hospital Flexibility Program.

4. Consumer experience with care

Measures of consumers' experience of care are the most subjective assessments of a provider's quality. Examples of consumer-based measurement sets include member satisfaction surveys, consumer ratings of physician and/or hospital quality, and consumer reports of complaints and grievances. Individual measures may focus on customer service, access to care, management

⁷ Donabedian, A. 1966. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly* 44; 166-203.

⁸ http://www.leapfroggroup.org/FactSheets/LF_FactSheet.pdf - 8/26/2003.

⁹ http://www.leapfroggroup.org/FactSheets/LF_FactSheet.pdf - 8/26/2003.

and coordination of care, communication, and interpersonal relations. Often, consumer assessments make up a small portion of a provider's quality rating and do not serve as the only index of quality. For example, for the National Committee for Quality Assurance (NCQA) accreditation of health plans, Ford Motor Company's hospital profiling project, and HealthScopes's evaluation of California hospitals, consumer satisfaction surveys or questions are one part of the quality equation.

TABLE 4. CONSUMER EXPERIENCE STANDARDS

<u>Standard</u>	<u>Consumer Experience Measures</u>	<u>Applications</u>
Consumer Assessment of Health Plans (CAHPS) www.cahps-sun.org	A comprehensive member satisfaction survey that rates health plan performance in areas such as customer service, access to care and claims processing. *NOTE: Focuses on primary care.	Used by managed care plans to demonstrate quality of care to customers.
Foundation for Accountability (FACCT) Consumer Information Framework www.FACCT.org	The framework's model organizes comparative information about quality performance into 5 categories based on how consumers think about their care: (1) The Basics; (2) Staying Healthy; (3) Getting Better; (4) Living with Illness; (5) Changing Needs. *NOTE: Focuses on primary care.	Results are intended to help consumers understand health care quality and compare the performance of health plans and providers.
Ford Motor's Company Hospital Profiling Project – The Picker Inpatient Survey http://www.hospitalprofiles.org/pdf/Atlanta_method.pdf	Survey questions grouped into seven dimensions of care: (1) Respect for patients' values, preferences, and expressed needs; (2) Coordination and integration of care; (3) Information, communication, and education; (4) Physical comfort; (5) Emotional support and alleviation of fear and anxiety; (6) Involvement of family and friends; (7) Transition and continuity. *NOTE: Focuses on primary care.	Focuses on assessment of interpersonal quality. Results are one component of the Hospital Profiling Project designed to provide employees and retirees with comparative information on hospital performance.

Assessing Detrimental Impact

There is significantly less information in the literature pertaining to the potential impact of increasing distance and travel time to health care. The information that does exist clusters around three general categories of impact (financial, clinical, and psycho-social) defined here.

1. Financial impact

Financial impact is perhaps the most obvious and quantifiable type of detrimental impact experienced by consumers. Financial impact includes the increased costs associated with travel, such as the price of gas, transportation, childcare, and meals/lodging for family members, as well as any reduction in actual or potential income that may result from increased time away from work and/or school.

2. Clinical impact

Clinical impact refers to any impact on the course of care that may be caused by increased travel, such as changes in a consumer's likelihood to seek out care, receive care, or comply with plans for follow-up treatment. In a study of the impact of geographic accessibility on the intensity and quality of depression treatment, Fortney et al (1999) found that travel time to a provider was significantly associated with making fewer visits to the provider and having a lower likelihood of receiving guideline-concordant treatment (i.e. sufficient number of visits).¹⁰ While this particular study is specific to consumers traveling for depression treatment, it is not implausible to think that other patient populations who must travel frequently for intense therapy or follow-up treatment might be deterred from seeking out and later following-up with appropriate appointments and procedures.

3. Psycho-social impact

A third area of impact involves the consumer's sense of psychological and social well-being. This includes the individual's general level of happiness, comfort, anxiety, and stress. Psycho-social impact is more difficult to measure as it is entirely subjective and not always observable. Nevertheless, traveling generally removes a person from his/her family and social supports, and there is evidence in the literature to support the claim that travel to a hospital disrupts the harmony of the family unit, specifically when it is a child who is the recipient of chronic care.¹¹ Other issues to consider when assessing psycho-social impact include the added stress of travel, especially during inclement weather and when road conditions are poor, and the additional difficulties encountered by more vulnerable populations, such as the elderly, disabled and economically disadvantaged.¹²

Interview Findings

As previously noted, interviews were conducted with twenty-nine individuals representing twenty-one stakeholder groups. A distillation and summary of the comments, observations and opinions provided by these individuals follows.

¹⁰ Fortney, J, Rost, K, Zhang, M, and Warren, J. 1999. The impact of geographic accessibility on the intensity and quality of depression treatment. *Medical Care*. 37(9) 884-893.

¹¹ Yantzi, N, Rosenberg, MW, Burke, SO, and Harrison, MB. 2001. The impacts of distance to hospital on families with a child with a chronic condition. *Social Science & Medicine*. 52:1777-1791.

¹² Reif, SS, DesHarnais, S, and Bernard, S. 1999, Spring. Community perceptions of the effects of rural hospital closure on access to care. *The Journal of Rural Health*. 15(2) 202-209.

Providing Better Quality Services

Interview participants were initially requested to identify specific examples of “better quality services” and, in the absence of specific examples, the criteria and processes that BOI might use to implement this standard.

While examples varied from the very specific to the general, three themes evolved:

1. Documentation of better quality services must be based on objective, science-based, independent information that identifies the efficacy of specific procedures and protocols or evaluates their impact on outcome. Peer-reviewed literature was suggested as the best source for this information. Professional associations were also noted as potential information sources. Specific examples of informational resources that met this standard included Leapfrog metrics and other volume-sensitive measures.

There was less unanimity with regard to a number of other popular references typically based on claims data. Designed to facilitate reimbursement arrangements, there is some evidence that claims data do not adequately capture valid and reliable clinical information.

Consequently, claims data may not be appropriate substitutes for information derived from the medical record and other primary clinical sources. In addition, some popular references, such as Healthgrades.com, rely on a single payer’s information (Medicare).

Concern was also expressed about reaching conclusions based on comparisons of certain quality measures between institutions and specialty groups, i.e., mortality rates, readmission rates, complication rates. Oftentimes, an insufficient number of observations make it impossible to draw statistically significant findings.

2. Most measures of better quality services will be procedure specific. It is difficult to extrapolate procedure specific findings to reach a conclusion about an entire institution or specialty practice. While a number of interviewees identified patient safety, shared decision support and computerized pharmacy order entry systems as processes consistent with providing better quality services, few were prepared to suggest that these processes were adequate to designate an entire institution or specialty practice as providing better quality across the complete range of all services available.

Notwithstanding the above conclusion, certain processes, when focused on a specific procedure, can serve as indications of better quality services when documented in the literature. These may include such processes as disease registries in specialists’ office.

3. Finally, a number of interviewees noted certain capacity measures as reasonable evidence of better quality services. For example, mental health practitioners who are dually licensed or have the expertise to provide a breadth of services (i.e., individual as well as family counseling) were more likely to promote seamless integration of care.

Similarly, the capacity to reduce the number of invasive procedures was submitted as a measure of better quality services. As an example, providers with the technology to provide both diagnostic and therapeutic angioplasties reduce patient exposure to one invasive procedure.

A number of interviewees identified non-clinical quality issues, including cultural competency,

language and provider capacity. In identifying these issues, the presumption is that such quality elements are available to consumers within existing time and distance limits. To the extent that a health plan constructively addresses these quality considerations in a designated provider, the health plan has not provided better quality services. If these factors are not replicated in a designated provider, a detrimental impact clearly exists and the health plan will have an obligation to address this impact (discussion to follow). While these factors should be considered in the designation process, these factors are in themselves not sufficient for designation purposes.

With the identification of any measure, the risk of unintended consequences was noted by a number of interviewees. If unnecessary utilization becomes a product of a volume-based indicator of better quality services, the purpose of Chapter 469 has been clearly defeated. It will be important to monitor better quality services based on objective and independent standards.

Unintended consequences might also be felt by rural hospitals. Many quality measures cited in the literature favor large hospitals by focusing on services that larger institutions are likely to provide in greater volume and scope. While it may be appropriate to designate large institutions for specialized services, designation should avoid undermining the rural hospital's market share for core primary and secondary acute services. This conflict may be short-lived if rural hospitals pursue opportunities to develop high quality programs in certain areas through better regionalization of resources. Moreover, Chapter 469 seeks to mitigate this undermining by exempting primary, preventive, maternity, obstetrical, ancillary or emergency care services.

An additional fear was that, by allowing for financial incentives for designated providers, Chapter 469 would encourage carriers to establish benefit plans with larger cost sharing provisions in their plans for those services where designated providers were available. This trend is more likely to occur for employee populations that are very concentrated in geographic areas where designated providers would be available for most, if not all, insured consumers.

Evaluating Detrimental Impact

Presuming that providers of better quality services are identified, Chapter 469 further requires the carrier to demonstrate that the quality improvements significantly outweigh any detrimental impact to covered persons or that the carrier has taken steps to effectively mitigate any detrimental impact.

Most respondents struggled in defining and suggesting an approach to evaluating detrimental impact. In part, the very subjective nature of this issue made it difficult to articulate a single standard. A number of respondents noted that there would be no detrimental impact if higher quality services were provided. Others suggested a number of non-clinical considerations important to a patient's good health, the absence of which would be detrimental. These included cultural competency of the provider, language, and capacity. These exist as potential detrimental issues to the extent that they are presently addressed by providers within current distance and time limits.

Given the voluntary participation by consumers, some interviewees noted that patients ultimately will evaluate if the additional quality offsets their specific detrimental impact. For most and in light of the very modest extension of travel limits, the detrimental impact is likely to be minimal, if any.

Most respondents did acknowledge and identify a number of likely inconveniences. These included: travel expenses, separation from family and friends, additional time away from work, and the potential for reduced coordination of care with local providers. Travel expenses and overnight accommodations are sometimes offered by carriers to support patients traveling significant distances for specialty care. Many interviewees felt that such accommodations were likely to be unnecessary and administratively burdensome given the context and scope of Chapter 469, since the extended travel distances were modest. Nothing in Chapter 469 permits providing incentives for enrollees to travel more than 100 miles, via highway routes. In addition, it is likely that the financial provision offered by the carrier would be adequate to offset additional travel costs. Most importantly, enrollees are likely to overlook the inconveniences represented by some additional travel in order to avail themselves of better quality services.

Greater inconveniences would be likely for enrollees who require follow-up services for extensive periods of time. Cardiac rehabilitation services following open heart surgery was provided as an example. For these enrollees, as well as those with chronic illnesses, the additional travel distances may prove to be more burdensome. This issue has been, in part, contemplated by Chapter 469 which exempted “ancillary services” from longer travel distances. Ancillary services include some, but not all, services associated with rehabilitation and chronic care. In evaluating carrier claims of better quality services, an assessment of ongoing follow-up care and coordination of treatment plans should be provided.

It was highlighted by some respondents that inconvenience is very subjective. For frail, vulnerable or low income populations, the above “inconveniences” are substantially greater and may prevent the consumer from accessing services. For these populations, there may be more limited opportunity to access designated providers, regardless of the financial incentive.

Mitigating Detrimental Impact

Finally, satisfaction surveys were identified as important tools to monitor the impact of expanded travel distances on an ongoing basis as well as when a carrier requests recertification of the designation. Some respondents proposed the direct participation of consumers in the development and design of survey instruments as well as serving as an advisory resource to BOI in the recertification process.

Conclusions and Recommendations

A number of themes repeated in the literature and interviews influenced our recommendations. Any proposed method for evaluating a carrier’s compliance with the quality standards for designation of providers should be:

- Subject to objective measurement;
- Practical and reliable within the constraints of available data and resources;
- Independent and evidence-based;
- Flexible enough to be relevant to different services, procedures and service settings; and
- Enduring and adaptable to changes in the science of quality measurement or standards of care.

Our approach to evaluating a carrier's compliance is iterative. First, we propose general provisions that establish threshold considerations. Second, a process and standards for evaluating the service quality of providers are proposed. Third, core elements of detrimental impact are defined. Finally, methods for mitigating detrimental impact and conducting the review process are considered.

General Provisions

1. Institutional Provider versus Service Designation

Chapter 469 precludes carriers from designating providers of primary, preventive, maternity, obstetrical, ancillary, or emergency services.¹³ With these exceptions, major categories eligible for designation include non-obstetrical hospital inpatient services, outpatient surgical and diagnostic centers, and specialists.

Chapter 469 does not explicitly state whether designation of a provider is made at the service or institutional provider level. In assessing the level of designation that would be appropriate, the following factors have been considered.

- Chapter 469 references services, not providers, in the identification of entities that are exempt from designation. This would suggest that services, not providers, are eligible for designation.
- Assessment of quality can best be done at the service level. No single global measure for evaluating and comparing the overall quality of hospitals or outpatient surgical centers exists. Although there are emerging methods for creating indices of hospital quality based on a composite score of individual measures, these tend to be more effective in differentiating among groups of hospitals and do not adequately discriminate between the performance of any two hospitals.
- There is lack of evidence that one can infer from the quality of care for one service or procedure to the quality of care for all services or procedures.¹⁴ Thus a facility or specialist that is shown to perform well in treating patients with acute myocardial infarction cannot be assumed to do well in other areas of cardiac care.
- There is less likelihood that carriers will rush to “devalue” their plans if the designation occurs at the service level.

Recommendation: Designation should be approved at the service rather than institutional provider level.

¹³ As defined in Rule Chapter 850.

¹⁴ Brook, R., McGlynn, E., Cleary, P. Part 2: Measuring Quality of Care. The New England Journal of Medicine, September 1996; 966-970.

2. Specialty Practice versus Service Designation

Designation is more difficult when considering services at the specialty practice level. Standards and criteria at this level are less well established. In addition, a carrier's data for a specialty practice will be limited to its enrollee population and will likely represent significantly less than the total services provided by the practice. With few exceptions, assessments of quality at the specialty practice level must rely on structural and process measures integral to the operations of the practice rather than the performance of an individual service rendered by the practice.

Recommendation: In addition to service-specific designation at the individual provider level, designation may be made at the specialty practice level.

3. Period of Designation

The length of designation is not stipulated in Chapter 469. In recommending the appropriate interval before conditions that lead to the initial designation are re-evaluated, we have considered several issues:

- How soon would conditions be expected to change? A one-year interval appeared too brief a time to establish the referral arrangement, notify enrollees and providers of the terms for use, and have sufficient experience upon which to evaluate impact. A three-year designation may be too long if the detrimental impact was significantly more deleterious than anticipated. A two-year designation period would provide sufficient opportunity to establish, use and evaluate the impact of the designated provider.
- What processes are in place to facilitate re-designation? We examined other regulatory processes that could coincide with the re-designation process to reduce burden on behalf of carriers and BOI review staff. Health insurance carriers are required to submit annual filings on their Access Plans. Similarly, preferred provider organizations are required to be registered on an annual basis. The State conducts onsite audits of health maintenance organizations every three years, including reviews of a carrier's compliance with Rule Chapter 850 and internal quality management program standards.

Recommendation: Designation of a provider has a term of two years after which a renewal application must be submitted with the carrier's annual filing with BOI.

Defining Better Quality Services

Our task was to define criteria for BOI to assess a carrier's claim that a specified service of a designated provider is superior to the same service within routine travel limits. The task confronted three obvious challenges:

- The range of possible services is endless.
- There is a plethora of quality standards that a carrier could employ to make the case for quality.
- The state of the art in quality measurement is fluid.

We sought to address these challenges without burdening the system or jeopardizing a uniform approach to each review. We also wanted a process that could evolve over time, as experience and new knowledge was gained that may influence the approval process.

The desire to build flexibility into the review system capable of responding to varied requests meant that no fixed standard of quality could be used. However, it was crucial that any standard have face validity and be professionally recognized as an indicator of quality. Ideally, it was important that there be a benchmark indicating the desirable level of performance. Finally, we concluded that the designation process for a service would differ from one in which the carrier sought designation for a specialist practice.

Recommendation:

Service Designation

In applying for the designation of a service delivered by an institutional provider or specialty practice, the carrier must:

- I. Specify the provider of the service to be designated and comparable services within the standard travel time.
- II. Demonstrate superior quality of the proposed service through one or more of the following (see Appendix C for illustrations):
 1. Clinical outcomes are superior.
 2. Processes of care are superior.
 3. Structures or systems associated with better quality are superior.
- III. Document to the satisfaction of the Superintendent that:
 1. Standards used to demonstrate superior quality are nationally recognized, evidence-based and documented in the literature.
 2. Data used to compare providers are reliable and consistent across providers.
 3. Findings from quality assessments are verifiable as statistically significant by an entity independent of the carrier.
 4. All competing service providers within routine travel time are included in the comparison.

In assessing service quality, the Superintendent will consider:

- The designated service meets or exceeds absolute benchmarks of quality that are evidence-based (e.g., volume-sensitive standards). No preference will be given to a service provider that falls below an established benchmark, even when performance is relatively closer to the benchmark than that of other providers, unless combined with other factors.
- Relative performance exceeds other providers when evaluated against standards that have no absolute benchmark.
- When multiple measures exist for a given service, quality differences are substantiated by more than one quality measure.
- Documentation that the designated provider has established a structure or system to communicate with local providers responsible for primary, emergent, and/or follow-up care.

Specialty Practice Designation

In applying for the designation of a specialty practice, the carrier must:

- I. Specify the specialty practice to be designated and comparable specialty practices within standard travel limits.
- II. Demonstrate superior quality of the specialty practice through one or more of the following (see Appendix C for illustrations):
 1. Clinical outcomes are superior.
 2. Processes of care are superior.
 3. Structures or systems associated with better quality are superior.
- III. Document, where applicable, to the satisfaction of the Superintendent that:
 1. Standards used to demonstrate superior quality are nationally recognized, evidence-based and documented in the literature.
 2. Data used to compare providers are reliable and consistent across providers.
 3. Findings from quality assessments are verified as statistically significant by an entity independent of the carrier.

In assessing service quality of the specialty practice, the Superintendent will consider:

- The specialty practice exceeds performance standards and/or credentials of comparable specialty practices.
- The specialty practice engages in quality management activities that promote effective care, such as automated clinical information, computer-based clinical decision support systems, or use of performance and outcome measurement for quality improvement initiatives.
- The specialty practice has a contractual arrangement with the carrier requiring external oversight of care quality as demonstrated by routine data submission and review to assess compliance with evidence-based protocols, performance and outcome measurement, and participation in quality improvement initiatives.
- Documentation that the designated provider has established a structure or system to communicate with local providers responsible for primary, emergent, and/or follow-up care.

The Superintendent may engage independent, outside expertise to assist in evaluating the quality of services and specialty practices.

Determining Detrimental Impact

Detrimental impact was discussed primarily in terms of extended travel from an enrollee's residence, the associated time and expense of travel, and the loss of proximity to one's support network. Several considerations influenced our recommendation:

- Any measurement of detrimental impact must be undertaken within the context of the modest expansion of travel and time limits allowed under this exemption. Chapter 469 expands the maximum travel from 50 to 100 miles from an enrollee's residence. Allowed travel time

varies depending on road conditions but under normal conditions does not exceed 2 hours.

- The decision to go to a designated provider is a voluntary one, with the enrollee retaining the right to seek care within the routine service area.
- Assessment of detrimental impact is driven by both objective and subjective considerations and is highly variable depending on the circumstances of an individual enrollee and his/her family.
- While acknowledging the subjective nature of detrimental impact, encouraging the identification and use of higher quality providers is a very appropriate policy objective, particularly when consumers suffer no diminution in coverage or access if they do not avail themselves of designated providers.

Recommendation: Detrimental impact is an individual calculation of travel costs, including mileage, meals and overnight expenses, and all attendant costs associated with family disruption and potential loss of work.

Methods for Mitigating Detrimental Impact

Chapter 469 requires the carrier to mitigate any detrimental impact unless such impact is outweighed by the quality improvements of the designated provider. Four factors led to our recommendation:

- The financial incentive offered by a carrier is intended both to encourage an enrollee to use a designated provider as well as to mitigate the detrimental impact related to increased travel and inconvenience.
- The calculation as to whether the financial incentive is sufficient to mitigate against detrimental impact is made by the consumer when evaluating the tradeoffs between accessing a designated provider and potentially traveling up to an additional hour. If the perceived benefits of the financial incentive in combination with the improved quality of a designated provider do not outweigh the burden of increased travel, an enrollee has the option to receive the service within the service area under the terms of a carrier's routine cost sharing arrangements.
- Extending relief beyond the financial incentive is likely to unfairly incent an enrollee to use the designated provider causing further erosion in local service provision.

Recommendation: We propose that no additional mitigation be required to compensate an enrollee for detrimental impact associated with the use of a designated provide insofar as maximum travel time to a preferred provider does not exceed 2 hours or 100 miles. As a condition of designation renewal, however, we recommend that BOI review consumer experience in accessing care through designated providers and evaluate whether changes to the policy on mitigation are necessary. We further recommend that the BOI develop a standard instrument for use by carriers in surveying all enrollees who receive care through designated providers to evaluate perceived barriers or challenges in receiving that care, including coordination and transition of care between designated and local providers.

Chapter 469 offers a modest but important step in shifting how contracting and use decisions will be made for specialized services. By expanding travel allowances to access higher quality, Chapter 469 subscribes to the growing imperative that quality performance should be rewarded.

At the same time, safeguards preserve the traditional role of community providers in the area of primary, secondary and follow-up care.

A by-product of Chapter 469 and our proposed recommendations is the anticipated advancement in the use of evidence-based quality assessment tools. Initially, the requirement that carriers document their claims of better quality through the use of evidence-based criteria will limit the kinds of services eligible for designation. As science and data improve, however, this provision can accelerate the application of measurement tools for decision-making. We anticipate a strong role for the Maine Quality Forum in disseminating and endorsing acceptable approaches to measuring quality.

Our recommendation not to require mitigation of detrimental impact beyond the financial incentive is not static. It was made within the strict context of the 100-mile or 2-hour travel time and the stipulation that consumer experience be reviewed at the time of re-designation. While mitigation is not viewed as an entitlement in our recommendations, carriers should make every effort to facilitate easy access to services and provide recourse when consumers are particularly challenged in accessing their designated provider.

Appendix A: Key Informants

William Altman, Network Manager, Provider Network Management, Anthem Blue Cross and Blue Shield

B. J. Bangs, Communications Manager, National Multiple Sclerosis Society of Maine

John Benoit, President, Employee Benefits Solutions, Inc.

Carol Carothers, Executive Director, National Alliance of the Mentally Ill-Maine

Vincent Conti, President and Chief Executive Officer, Maine Medical Center

Leo Delicata, Managing Attorney, Legal Services for the Elderly

Joseph Ditre, Executive Director, Consumers for Affordable Health Care

Katie Fullam Harris, Director of Government Relations, Anthem Blue Cross and Blue Shield

Catherine Gavin, Executive Director, Maine Healthcare Purchasing Collaborative

Jana Harbaugh, LCSW, Team Leader, Deaf Counseling Services

Peter Hayes, Director of Health Strategy, Hannaford Foods

Stephen M. Jennings, Associate State Director - Advocacy, AARP Maine

Frank Johnson, Executive Director, Division of Employee & Health Benefits, Maine Bureau of Human Resources

Norman Ledwin, CEO, Eastern Maine Medical Center

Douglas Libby, Executive Director, Maine Health Management Coalition

Andrew B. MacLean, General Counsel & Director of Governmental Affairs, Maine Medical Association

Mary Mayhew, Vice President of Government Affairs, Maine Hospital Association

Peter McCorison, Mental Health and Substance Abuse Service Manager, Aroostook Mental Health Center

Dorothy Merrick, Volunteer Senior Advocate/Member, Maine Council of Senior Citizens

Steven Michaud, President, Maine Hospital Association

Kellie Miller, Executive Director, Maine Osteopathic Association

Nancy Connelie Morris, Director of Marketing, Maine Health Alliance

Sandra Parker, Esq., General Counsel, Maine Hospital Association

Peter M. Rice, Esq., Litigation Director, Disability Rights Center

Sharon L. Roberts, Director, Stakeholder Relations, Anthem Blue Cross and Blue Shield

Michelle A. Small, Esq., Health Policy Analyst/Staff Attorney, Consumers for Affordable Health Care

Peter Walsh, Acting Commissioner, Maine Department of Human Services

David Winslow, Vice President of Financial Policy, Maine Hospital Association

Appendix B: Interview Protocol

Date: _____ Location: _____

Name of Interviewees, position and organization: _____

_____ (get contact information if needed)

Name of Interviewer and other project team members in attendance: _____

Describe scope of this project and objectives. Describe role of Bureau of Insurance and Muskie School of Public Service. Describe process and timetables.

Begin interview.

LD 1611 permits a health plan to provide financial incentives to a covered person to a select provider beyond the travel limits presently defined in Rule 850, if “better quality services” are provided. In no event can the financial incentives be utilized to permit travel that is twice the mileage and travel limits defined in Rule 850.

Example: A health plan contracts with two providers of the same specialty service. One is located within 20 miles of the subscriber’s home, well within the access limits of Rule 850, and the other is located 55 miles from a subscriber’s home. The health plan will reduce co payments by one half if the subscriber receives services from the specialist provider who is located 55 miles away. This second distance is outside the limits of Rule 850 but would be within the expanded distances permitted under LD 1611 IF BETTER QUALITY SERVICES WILL BE PROVIDED AT THIS MORE DISTANT LOCATION.
--

1. Can you suggest specific examples of better quality services that can be used to differentiate providers?

2. In the absence of specific examples, what would you suggest as criteria for establishing better quality services?

3. What process, if any, would you propose for purposes of defining better quality services?

4. Do you have any other suggestions/comments as to defining better quality services?

IN ADDITION to providing “better quality services” LD 1611 requires the health plan to demonstrate that the quality improvements “either significantly outweigh any detrimental impact to covered persons...*OR* the carrier has taken steps to effectively mitigate any detrimental impact” [emphasis added].

Example: Providing a beneficiary a financial incentive to access a particular provider might be considered to have the detrimental impact of requiring twice the travel for the beneficiary and his or her family. The requirements of LD 1611 are satisfied if: the carrier documents the clinical outcomes for the necessary service is statistically higher for this provider or the carrier provides mileage reimbursement to the beneficiary and his or her family for the extra travel distance.
--

5. What process would you suggest for evaluating how the quality improvement significantly outweighs any identified detrimental impact?

6. Given the new travel time and distance limits established by LD 1611, would there be any detrimental impact to beneficiaries? If yes, please provide examples.

7. For the detrimental impacts that you listed in Question 7, what would you propose as steps to effectively mitigate these impacts?

8. What criteria would you suggest for purposes of identifying other detrimental impact?

9. What criteria and process would you suggest for assessing methods to mitigate any detrimental impact identified by the criteria in Question 9?

10. Do you have other suggestions/comments as to defining detrimental impact or methods for mitigating against detrimental impact?

Thank interviewees for their time and note that they will receive a copy of the Muskie report to the Bureau of Insurance.

Appendix C: Potential Measures for Assessing Quality

Clinical outcomes

- Performance against nationally recognized volume-sensitive standards
- Risk-adjusted outcomes as defined by professionally accepted quality measures

Processes of care

- Application of nationally accepted practice protocols
- Performance as defined by professionally accepted quality measures
- Provision of an expanded scope/breath of service that promotes service efficiencies or reduces clinical complications

Structures or systems associated with better quality

- Physician-order entry systems
- Electronic medical records
- Advanced certification
- Consumer satisfaction
- Participation in quality management practices
- Participation in systems of care requiring external quality oversight